Guide to Quality Performance Scoring Methods for MaineCare Accountable Communities—Revised (3/11/14)

Introduction

The purpose of this document is to provide guidance on quality performance scoring in the Maine Department of Health & Human Services' (the Department) MaineCare Accountable Communities (AC) initiative.

Background

Please reference the Accountable Communities RFA at http://www.maine.gov/dhhs/oms/vbp/accountable.html for more information on the Accountable Communities initiative.

The Department has largely based its quality scoring methodology on the Medicare Shared Savings Program (MSSP) methodology (available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2012-11-ACO-quality-scoring-supplement.pdf). This summary is adapted from the MSSP summary. Maine has adopted the same four quality domains, minimum attainment levels, and a very similar scoring point system and sliding scale to the MSSP. The Department diverges from the MSSP quality framework in its number and selection of measures, benchmark sources, and the requirement for ACs to choose elective measures in addition to the core measures. Maine has selected quality metrics that reflect the needs of the MaineCare population and areas the Department wants to target for improvement. Wherever possible, these metrics align with other Department and CMS initiatives and areas of focus, including the Health Homes initiative, Maine's Improving Health Outcomes for Children (IHOC) grant, Medicare ACO's, Meaningful Use, CMS Medicaid Adult core measures and Children's Health Insurance Program. The Department has committed to reviewing the Quality Framework on an annual basis in order to better achieve multi-payer alignment under the Maine State Innovation Model (SIM) process and to adjust measures as otherwise deemed appropriate.

Before an AC can share in any generated savings, it must demonstrate that it met the quality performance standard for that performance year. The Department will measure quality of care using 15 core measures and six elective measures across four key domains. The core and elective measure sets consist of those measures for which the AC has accountability for payment purposes. ACs must select three of the six elective measures on which to be measured together with the core measure set, for a total of 18 measures tied to shared savings payment per AC. In addition, the Department has currently identified five measures for monitoring and evaluation purposes only. The measures designated for monitoring and evaluation will not be tied to payment. The Department is in the process of reviewing other potential measures to track for monitoring and evaluation.

1. Patient/caregiver experience (1 core measure)

2. Care coordination/patient safety (4 core measures, 1 elective measure, 2 monitoring and evaluation measure)
3. Preventive health (4 core measures)
4. At-risk population:
    - Asthma (1 core measure, 1 elective measure)
    - Diabetes (3 core measures, 2 elective measures, 2 monitoring and evaluation measure)
    - Chronic Obstructive Pulmonary Disease (COPD) (1 elective measure)
    - Coronary artery disease (CAD) (1 elective measure)
    - Behavioral Health (2 core measures, 1 monitoring and evaluation measure)

Quality Performance Scoring

The majority of the 21 core and elective quality measures are claims-based in order to enable the Department to focus on the measurement of performance from the outset of the initiative. In addition to claims-based measures, the Department will utilize:

- Clinical information from the state's Health information Exchange to calculate performance measures on Diabetes HbA1c control
- Reporting from the Medicaid electronic health records (EHR) Incentive Program to determine physician qualification for EHR Meaningful Use
- Reporting to the national CG-CAHPS database on patient experience of care

With the exception of the EHR and patient experience measures, the Department will calculate the measures for each AC based on its attributed population. The Department will report on each AC's quality performance on a quarterly basis. The Department will conduct quality scoring in order to determine final shared savings payments at the end of the performance year.

Administration of a standardized survey of patient/caregiver experience of care through the Clinician Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) is required in order for an AC to receive a full quality score. The Department is exploring potential means to subsidize the cost of the CG-CAHPS administration for Year 1 of Accountable Communities, but cannot commit to providing financial assistance at this time.

In the care coordination domain, the EHR measure is double weighted both for scoring purposes and for purposes of determining poor performance.

Pay for Performance

The performance year and the reporting period for quality measurement purposes will be the 12-month period beginning on the implementation date and annually thereafter for the duration of the agreement period. All but three of the 21 core and elective measures combined will be pay for performance. Of the remaining three measures, two measures, developmental screening in the first three years of life and Adult Diabetes - Glucose Control, will transition to pay for performance in Year 2. The Department is still determining whether the second

measure, CG-CAHPS patient experience, could transition to pay for performance for Year 3. At a minimum, the measure would evolve from reporting on all payers to reporting exclusively on MaineCare beneficiaries' experience.

The Department will establish benchmarks for quality measures using national Medicaid data wherever available. There are seven measures for which there is no national Medicaid benchmark available. As appropriate, the Department will utilize MaineCare Health Homes and PCCM data, national Medicare data, and Maine EHR Meaningful Use incentive program data where national benchmarks are not available. Should a national Medicaid benchmark become available, the Department will begin use of that benchmark in the next performance year after it becomes available.

Minimum Attainment Level for Quality Measures

For pay-for-performance measures, the Department defines the minimum attainment level at 30 percent or the 30th percentile, depending on what performance data are available. Below this level, the AC would score zero points for the measure

An AC may earn points for meeting the minimum attainment level on each measure. If the AC crosses the minimum attainment level on at least one measure in each of the three pay for performance domains (Patient/ Caregiver Experience domain is excluded), it will earn points and therefore be eligible to share in a portion of the savings it generates. The AC must also meet the cost savings criteria to be eligible for shared savings payments.

Quality Scoring Points System

As illustrated in Table 1, a maximum of 2 points could be earned for each quality measure, with one exception. In alignment with the Medicare AC quality scoring system and reflective of the importance of the adoption and meaningful use of EHRs, the EHR measure will be double weighted and will be worth up to 4 points to provide incentive for greater levels of EHR adoption.

Table 1. Total Points for Each Domain within the Quality Performance Standard

Domain	# Core Measures	# Elective Measures (must choose 5)	Monitoring & Evaluation Only Measures	Total Possible Points Per Domain	Domain Weight
Patient/ Caregiver Experience	1	0	0	2	10%
Care Coordination/ Patient Safety	4	1	2	10 – 12	30%
Preventive Health	4	0	0	8	30%
At-Risk Population	6	5	3	16 - 18	30%
Total	15	6 (choose 3 total)	5 (may add others)	38	100%

Quality Scoring Sliding Scale

While Table 1 shows the possible maximum points that may be earned by an AC, quality scoring will be based on the AC's actual level of performance on each measure. As detailed in the final rule, an AC will earn quality points on a sliding scale based on level of performance. The higher the level of performance, the higher the corresponding number of quality points, as outlined in Table 2. The total points earned for measures in each domain will be summed and divided by the total points available for that domain to produce an overall domain score of the percentage of points earned versus points available.

Table 2.Sliding Scale Measure Scoring Approach

AC Performance Level	Quality Points per Measure	EHR Measure Quality Points
90+ percentile or percent benchmark	2 points	4 points
70+ percentile or percent benchmark	1.7 points	3.4 points
50+ percentile or percent benchmark	1.4 points	2.8 points
30+ percentile or percent benchmark	1.1 points	2.1 points
<30 percentile or percent benchmark	No points	No points

Financial Reconciliation Accounting for Quality Performance

The Department is implementing both a one-sided model (sharing savings, but not losses, for the entire term of the first agreement) and a two-sided model (sharing both savings and losses in Years 2 and 3 of the agreement), allowing ACs to opt for one or the other model. The maximum potential shared savings based on quality performance is 60 percent of the savings generated under Model II (the two-sided model) and 50 percent of the savings generated under Model I, the shared savings only model. The percentage of shared savings will vary based on the

AC's performance on the measures as compared with the measure benchmarks Actual shared savings payments may be eligible to an annual cap.

As shown in Table 1, each domain will be weighted equally. Accordingly, the percentage score for each domain, calculated using the methodology described previously, will be summed and multiplied by the domain weight. The Patient/ Caregiver Experience Domain receives a lower weighting due to the fact that it has one pay for reporting measure. The resulting overall percentage will then be applied to the maximum sharing rate under either Model I or II to determine the AC's final sharing rate for purposes of determining its shared savings payment.

Minimum Attainment Level for Each Domain of Care

ACs must meet the minimum attainment on at least 70 percent of the measures in each domain. If an AC fails to achieve the minimum attainment level on at least 70 percent of the measures in a domain, the Department may give the AC a warning, ask the AC to develop a corrective action plan, or put the AC in a special monitoring plan. Failure to meet the quality standard may result in termination. An AC that has been terminated from the program is disqualified from sharing in savings.